STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS

In the matter of

License #: AL630007355
SIR #: 2021A0988022
2021A0988028
2021A0988034

Adultcare of Independence Twp Inc
Heather Pines

_____/

AMENDED ORDER OF SUMMARY SUSPENSION
AND NOTICE OF INTENT TO REVOKE LICENSE

The Michigan Department of Licensing and Regulatory Affairs, by Jay Calewarts, Division Director, Adult Foster Care and Camps Licensing Division, Bureau of Community and Health Systems, orders the summary suspension and provides notice of the intent to revoke the license of Licensee, Adultcare of Independence Twp Inc, to operate an adult foster care large group home pursuant to the authority of the Adult Foster Care Facility Licensing Act, 1979 PA 218, as amended, MCL 400.701 et seq., for the following reasons:

1. On or about October 20, 1994, Licensee was issued a license to operate an adult foster care large group home with a licensed capacity of 20 at 8541 Eston Road, Clarkston, MI 48348.
2. Prior to the issuance of the license, and during subsequent modifications of the statutes and rules, Licensee received copies of the Adult Foster Care Facility Licensing Act and the licensing rule book for

adult foster care small group homes. The Act and rule book are posted and available for download at www.michigan.gov/lara.

Previous Licensing Rule Violations

3. On or about March 3, 2020, Licensing Consultant Frodet Dawisha completed Special Investigation Report (SIR) #2020A0605014 and cited Licensee with a violation of licensing rule R 400.15314(1). As a result of this violation Licensee submitted a corrective action plan (CAP) on or about May 9, 2020, to demonstrate compliance with the cited licensing rule violation. At the conclusion of this investigation license #AL630007355 remained at regular status.
4. On or about April 19, 2021, Licensing Consultant DaShawnda Lindsey completed SIR #2021A0993015 and cited Licensee with three licensing rule violations, including licensing rules R 400.15305(3) and R 400.15312(2). As a result of these violations Licensee submitted a CAP on or about May 7, 2021, to demonstrate compliance with the cited licensing rule violations. At the conclusion of this investigation license #AL630007355 remained at regular status.

Current Licensing Rule Violations

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5. On May 7, 2021 Licensing Consultant Kenyatta Lewis received complaint allegations that staff at Heather Pines (hereafter referred to as “the facility”) do not ensure that Resident K’s oxygen is being administered. Ms. Lewis also received an incident report stating that Resident S is often left in soiled

diapers for extended periods of time, staff do not comply with Resident S's blood draw orders and Resident S did not receive her prescribed anti-psychotic medications for four days.

6. On May 10, 2021, Ms. Lewis interviewed Kara Fielder, Support Coordinator Area Adult Agency. Ms. Fielder confirmed the allegations that Ms. Lewis received on May 7, 2021, and added that on May 4, 2021, she spoke with a facility staff member who stated that facility staff do not monitor Resident K's oxygen intake.
7. On May 19, 2021, Ms. Lewis conducted an unannounced on-site investigation of the facility and observed Resident K sitting at the dining table. Resident K was not wearing an oxygen mask and there was no oxygen mask or tank in the dining room.
8. During her May 19, 2021, unannounced on-site investigation Ms. Lewis interviewed home manager Tonya Prescott. Ms. Prescott stated that facility staff are required to change Resident S's diaper every two hours. Ms. Prescott admitted that on May 1, 2021, Resident S's relative arrived at the facility to transport Resident S to a medical appointment and Resident S's relative discovered that Resident S's diapers were soiled.
9. During her May 19, 2021, interview of Ms. Prescott, Ms. Lewis asked Ms. Prescott if Resident S's required blood work had been completed for April, 2021. Ms. Prescott confirmed that it was not completed due to the mobile blood lab that Resident S was going to for blood work had gone out of business.

10. During her May 19, 2021, interview of Ms. Prescott, Ms. Lewis asked Ms. Prescott about allegations that the facility does not maintain appropriate staff levels. Ms. Prescott confirmed that the facility has been short staffed and that there are 10 residents of the facility that use wheelchairs.
11. After interviewing Ms. Prescott during her May 19, 2021, on-site investigation Ms. Lewis reentered the facility and observed that Resident K was still not wearing his oxygen mask. Ms. Lewis asked direct care worker (DCW) Emily Serratos why Resident K was not wearing his oxygen mask and Ms. Serratos stated that the oxygen cord was too long to drag to the dining table. Ms. Prescott instructed Ms. Serratos to put Resident K's oxygen mask on him and Ms. Serratos took Resident K to his bedroom. Ms. Lewis followed and observed that Resident K's bedroom was approximately four feet from the dining table. Ms. Lewis entered Resident K's bedroom and observed an oxygen machine with a long oxygen cord on the floor.
12. During her May 19, 2021, on-site investigation Ms. Lewis interviewed Ms. Serratos regarding the allegations that Resident S's diaper is not being changed regularly. Ms. Serratos stated that Resident S's diaper is changed regularly but Ms. Lewis detected an odor of urine coming from Resident S and asked Ms. Serratos if she could detect the odor. Ms. Serratos claimed that the odor was coming from a soiled diaper in the trash can, but when the trash can was inspected there was no soiled diaper present. Ms. Serratos then bent down near Resident S and confirmed that Resident S's diaper was soiled and in need of changing.

13. On June 14, 2021, Ms. Lewis received Resident S's chart notes and Resident S's bowel movement log from Licensee Designee Sunil Bhattad. Ms. Lewis reviewed Resident S's bowel movement log and confirmed that facility staff failed to initial Resident S's bowel movements on the following dates: May 4, 2021, May 8, 2021, May 10, 2021, May 12, 2021, May 13, 2021, May 18, 2021, May 20, 2021, May 21, 2021, May 23, 2021, May 25, 2021, May 27, 2021, and May 29, 2021. Ms. Lewis also reviewed Resident S's chart notes for the period between March 9, 2021, to May 27, 2021 and observed the following entries:
    a. March 26, 2021: "Resident changed herself right before dinner 8:30 PM."
    b. April 1, 2021: "Resident changed herself 2:11 PM."
    c. April 20, 2021: "Resident changed herself before bed. 10:33 PM."
    d. May 19, 2021: "Resident in bed all shift. Refused getting up and kept refusing to get changed. 12:00 AM."
    e. May 20, 2021: "Resident defecated in her diaper and wouldn't acknowledge that she did it or lied that someone else did it. 6:52 PM."
14. On July 13, 2021, Ms. Lewis interviewed Relative K who stated that on or about May 11, 2021, she asked Ms. Prescott to take Resident K to the hospital after speaking to him and observing that he was having difficulty breathing. As a result, Resident K was taken to the hospital and treated for sepsis.

15. On July 13, 2021, Ms. Lewis spoke with Ms. Fielder who confirmed that on May 4, 2021, Resident K was admitted to St. Joseph Hospital in Pontiac, Michigan for treatment of congestive heart failure, fluid in his lungs and swollen legs. Resident K was discharged back to the facility on May 14, 2021, and Ms. Fielder stated that she spoke with a facility DCW who stated that no one at the facility ensures that Resident K wears his oxygen mask.
16. On July 13, 2021, Ms. Lewis interviewed Joy McLeese, Visiting Physicians Nurse Practitioner, who confirmed that during a visit to the facility on April 23, 2021, she observed that Resident K was not wearing his oxygen mask and his oxygen machine was turned off.
17. During her July 13, 2021, interview with Ms. McLeese, Ms. Lewis asked Ms. McLeese about the mobile blood lab closing, resulting in Resident S not being able to have blood drawn in April 2021, and if the facility had been notified of the mobile blood lab's closing to make alternate arrangements for Resident S. Ms. McLeese stated that she informed Ms. Prescott that the mobile blood lab had closed, and that Relative S needed to be informed to take Resident S to her doctor to have blood work completed. Ms. McLeese stated that Ms. Prescott never informed Relative S.
18. During her July 13, 2021, interview with Ms. McLeese, Ms. Lewis asked Ms. McLeese if the facility is short staffed. Ms. McLeese stated that the facility is often short staffed due to the facility having 10 residents who use wheelchairs.

19. On July 14, 2021, Ms. Lewis interviewed Christy Frazier, the former Operations Manager of the facility. Ms. Frazier stated that she stopped working at the facility in February 2021 but when she worked at the facility, she was responsible for creating the staff schedules. Ms. Frazier stated that when the staff schedules were created there would be two DCWs during the day and two during sleeping hours. Ms. Frazier stated that there were times when two DCWs was adequate but admitted that often at least three DCWs was necessary to provide appropriate care and supervision of the facility residents.
20. On July 19, 2021, Ms. Lewis interviewed facility DCW Alana Dunavent who stated that she usually works at the facility from 3:00 p.m. until 11:00 p.m. Ms. Dunavent stated that when she would arrive for her shift Resident S was usually in a soiled diaper, and that a few times it appeared that Resident S had been in a soiled diaper for hours. Ms. Dunavent confirmed that there are staffing issues at the facility. Ms. Dunavent also stated that staff will often fail to attend their scheduled shift, resulting in the facility only having one direct care staff member for the bedtime shift, or DCWs working double shifts to cover for the staff member who failed to appear.
21. On July 19, 2021, Ms. Lewis received from Mr. Bhattad an email that contained Resident S's Medication Administration Record (MAR) for May 2021. Upon her review of the MAR Ms. Lewis confirmed that Resident S is prescribed Clozapine 100mg to be administered at 8:00 a.m. and Clozapine 200mg to be administered at 8:00 p.m. daily, and that neither of these

medications were administered to Resident S from May 1, 2021, through May 4, 2021. Mr. Bhattad also provided Ms. Lewis with staff schedules for April and May 2021. Ms. Lewis reviewed the schedules and observed that there were two direct care workers scheduled during the day and only one direct care worker scheduled during sleeping hours.

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22. On August 4, 2021, Ms. Lewis conducted an on-site investigation of the facility and reviewed the facility's resident register. The register stated that the facility has 15 admitted residents and two short term respite care residents. Ten of the residents require wheelchairs.
23. On August 27, 2021, Ms. Lewis received a text message from complainant that included a picture of Resident A standing in front of the facility's medication cart that had resident medications accessible.
24. On September 1, 2021, Ms. Lewis interviewed home manager Katelyn O'Hara who stated that on August 25, 2021 she called hospice after hours when she observed Resident S's neck bleeding profusely. A hospice nurse arrived and treated the wound and the hospice nurse observed maggots in Resident S's neck wound. The hospice nurse removed a maggot from Resident S's neck wound and placed a bandage on the wound. On August 26, 2021, a hospice aide was giving Resident S a shower and discovered more maggots in Resident S's neck wound when she removed the bandage.
25. On September 1, 2021, Ms. Lewis interviewed Lauren Roediger, a registered nurse employed with Careline Hospice. Ms. Roediger stated that she has

several concerns with the care the facility is providing to the residents. Ms. Roediger stated that she visits the facility each day and has observed that Ms. O'Hara is tasked with being the home manager along with providing direct care to residents. Ms. Roediger feels that there are too many residents that require a higher level of supervision that two DCWs can provide. Ms. Roediger stated that there are at least two staff members who bring their children to the facility during their employment shifts, including Ms. O'Hara, and that there have been several incidents of staff working alone.

26. During the September 1, 2021, interview Ms. Roediger informed Ms. Lewis that on July 29, 2021, she arrived at the facility and observed Resident X lying in bed soaked in urine and feces that had begun to stick to her skin. Ms. Roediger stated that Resident X passed away at the facility on July 29, 2021, while sitting at the dining room table. Ms. Roediger stated that DCWs failed to notice that Resident X had passed away for hours. Ms. Roediger stated that on July 29, 2021, Chaplain Don Albright of Careline Hospice visited with Resident X at the dining room table at approximately 2:30 p.m. At 6:00 p.m. Relative X arrived and discovered Resident X had passed away at the dining room table. DCW Deanna Kester called 911 and when the ambulance arrived Resident X was experiencing rigor mortis. Ms. Roediger stated that on August 26, 2021, she observed Resident A completely soaked in urine sitting in a recliner chair in the living room of the facility. Resident A's undergarment and pants were completely soaked with urine soaking through the fabric of the recliner chair. The recliner chair did not have a urine pad,

which could have led to other residents sitting in Resident A's urine if they sat in the recliner chair after Resident A left the chair. Resident A's skin was reddening due to being soaked in urine. Ms. Roediger stated that on August 30, 2021, she arrived at the facility and observed Resident A and Resident G lying in their beds in soaked undergarments.

27. During the September 1, 2021, interview Ms. Roediger confirmed that Resident A had maggots in his neck wound. Ms. Roediger stated that on August 24, 2021, she observed Resident A's neck wound was uncovered and had developed a black scab that would not peel off. Ms. Roediger stated that from June 2021 through August 2021 she visited Resident A twice weekly at the facility and during those visits she never observed a bandage on Resident A's neck. The neck wound had been infected several times, but Ms. Roediger stated that facility staff were "too lazy" to change Resident A's bandages. Ms. Roediger stated that on August 26, 2021, she went to the facility after receiving information from a hospice aide that when showering Resident A "a family of maggots was discovered in the neck wound." Resident A had to be sedated with morphine and Ativan to have the maggots removed. Ms. Roediger stated that she removed 28 maggots from Resident A's neck wound. There were 2-2.5-centimeter-deep tunnels in the wound and the wound had to be flushed several times to ensure that the wound was clean prior to being bandaged.

28. During the September 1, 2021, interview Ms. Roediger informed Ms. Lewis that hospice residents are not bathed by facility staff in between hospice aide visits even if the facility residents defecate themselves.
29. On September 1, 2021, Ms. Lewis interviewed Relative D who stated that Resident D and other facility residents were repeatedly left on the floor after falling out of bed during the midnight staff shift. Relative D stated that DCW Kester worked the midnight staff shift and admitted that she did not want to lift the residents on her own and waited until the day shift staff arrived to assist her with lifting the residents back into their beds.
30. On September 1, 2021, Ms. Lewis interviewed DCW Zaire Thomas who confirmed that she worked at the facility with Ms. Kester on July 29, 2021, from 3:00 p.m. to 11:00 p.m. Ms. Lewis confirmed that Resident X was found deceased at the living room table and that Ms. Kester called 911 when Resident X was discovered deceased. Ms. Thomas was unsure how long Resident X was deceased prior to Ms. Kester calling 911.
31. On September 1, 2021, Ms. Lewis interviewed Ms. Dunavent who stated that Mr. Bhattad and Sheba Kumar constantly ask her to cover facility shifts. Ms. Dunavent stated that on August 28, 2021, she worked alone at the facility for approximately three hours in the afternoon after Mr. Bhattad left early.
32. On September 2, 2021, Ms. Lewis interviewed Relative X who stated that on May 28, 2021, Resident X fell during the night. Relative X stated that Ms. Kester found Resident X on the floor but did not assist Resident X back into her bed until additional staff arrived for the morning staff shift. DCW

Dunavent noticed that Resident X's hand was swollen, and Relative X requested an X-ray which confirmed that Resident X suffered a fractured hand. Relative X stated that she arrived at the facility at approximately 5:50 p.m. on July 29, 2021, and she observed Resident X hunched over in her wheelchair. Relative X touched Resident X's arm and yelled out to Resident X who was unresponsive with green mucous hanging from her nose to her lap. Relative X asked Ms. Kester how long Resident X had been at the dining table and Ms. Kester stated that she had wheeled Resident X to the dining table approximately 30 minutes prior to Relative X's arrival. Ms. Kester attempted CPR and Relative X yelled to her that Resident X had a do not resuscitate (DNR) on file. Ms. Kester called 911 and when the ambulance and police arrived it was observed that Resident X's arm was stiffening, and rigor mortis had begun to set in with Resident X.

33. On September 2, 2021, Relative X provided the Independence Township Fire Department and the Oakland County Sheriff's Department reports documenting Resident X's death on July 29, 2021. Both reports confirm that paramedics observed Resident X at the facility's dining room table at approximately 6:26 p.m. Both reports also confirm that Resident X was cold to the touch in a warm environment and Resident X's neck and jaw were hard to move with obvious signs of rigor mortis setting in. Oakland County Sheriff officer Boucherr documented that on July 29, 2021, he was dispatched to the facility at 6:16 p.m. and upon his arrival he observed Resident X slouched at the dining room table. Paramedic Ron Bray was present and pronounced

Resident X deceased. Resident X's body was cold and stiff with rigor mortis setting in. Mr. Bray stated that in his medical opinion Resident X had been in the seated position at the dining room table for approximately one hour. Relative X stated that according to the hospice nurse and hospice pastor Resident X was placed at the dining room table at approximately 2:00 p.m. DCW Thomas stated that she began her staff shift at 3:00 p.m. and Resident X was in the exact location and position as when she was pronounced deceased. Relative X also stated that Resident X was not bathed regularly until she complained to Mr. Bhuttad and Ms. Kumar.

34. On September 2, 2021, Ms. Lewis interviewed Ms. Dunavent who stated that Ms. French informed her and other staff that she left Resident D and Resident X on the floor of the facility several times during the midnight shift because she did not want to hurt herself by attempting to lift the residents back into their beds without assistance. Ms. French stated that on one occasion she provided Resident D with a pillow and blanket to sleep on the floor after Resident D fell out of her wheelchair.

35. On September 2, 2021, Ms. Lewis reviewed a hospice care note authored by Ms. Roediger dated July 29, 2021, at 12:12 p.m. which stated that Resident X was found in the same clothes and brief that she was placed in on July 26, 2019. Resident X was observed to be completely soiled in sticky stool that was stuck to Resident X. Resident X had foul smelling, cloudy, thick, milky urine in her foley catheter. Ms. Lewis reviewed a hospice care note authored by Ms. Roediger dated August 26, 2021, stating that at 9:19 a.m. Resident A

was soaked through his brief and pants with stale smelling straw urine. Resident A had redness to coccyx and buttocks where large bowel movement was noted when he was changed. Ms. Lewis reviewed a hospice care note authored by Ms. Roediger dated August 30, 2021, stating that at 10:16 a.m. Resident G's room smelled of stale urine and her brief was completely saturated through to the under pad. Ms. Roediger cleaned Resident G and changed her brief.

36. On September 2, 2021, Ms. Lewis interviewed Relative D who stated that Resident D was not showered regularly. Relative D stated that she spoke with Ms. Prescott who informed Relative D that Resident D could only receive sponge baths because facility staff did not have time to shower all the facility residents. Relative D stated that Resident D often had a foul odor and she washed Resident D's hair several times.
37. On September 2, 2021, Ms. Lewis downloaded and reviewed the incident report completed by Mr. Bhattad on July 29, 2021, that documented Resident X's death. Mr. Bhattad stated that Resident X was positioned at the dining room table at 5:40 p.m. on July 29, 2021, but through her investigative interviews Ms. Lewis correctly concluded that Resident X was positioned at the facility dining room table at approximately 2:00 p.m. As a result, Ms. Lewis correctly concluded that Mr. Bhattad provided false information in the incident report.
38. On September 2, 2021, Ms. Lewis interviewed Ms. O'Hara and provided her with the texted photograph that shows Resident A standing in front of

accessible resident medications. When reviewing the photograph Ms. O'Hara responded "If I am correct, those look like Resident B's meds. I think I was being pulled from the cart to check on something."

39. On September 7, 2021, Ms. Lewis interviewed the complainant who stated "Resident E was left in a wet brief for two hours on September 6, 2021. Mr. Bhattad and Ms. Kumar were working as DCWs due to staff calling off. Resident E reported that she told Ms. Kumar that she needed to be changed and Ms. Kumar said she would have to wait until shift change."
40. On September 7, 2021, Ms. Lewis received staff schedules from May, 2021 to August, 2021 from Mr. Bhattad. Upon her review Ms. Lewis confirmed that on July 4, 2021, Ms. Prescott worked alone at the facility from 10:00 p.m. until 11:00 p.m. Ms. Lewis also received resident shower logs and when she reviewed the August 2021 shower log, she noticed that Resident D, Resident G, Resident O and Resident P were not entered in the log, and as a result there was no confirmation that these residents had been showered.
41. On September 7, 2021, Ms. Lewis asked Licensing Consultant Frodet Dawisha to conduct an on-site visit of the facility. When Ms. Dawisha completed the on-site visit, she informed Ms. Lewis that she observed Mr. Bhattad and Ms. Kumar covering Ms. O'Hara's scheduled staff shift from 3:00 p.m. to 9:00 p.m. on September 3, 2021. DCW Thomas arrived at 11:00 p.m. and observed Resident E in a soiled brief. Ms. Thomas changed Resident E's brief and observed that Ms. Kumar initialed the brief at 6:00 p.m. Resident E informed Ms. Thomas that she asked Ms. Kumar at 9:00 p.m. to

change her soiled brief but Ms. Kumar told her she would have to wait. Resident E sat in a soiled diaper from 9:00 p.m. until 11:00 p.m.

42. On September 7, 2021, Ms. Lewis reviewed Resident A's August 2021 Medication Administration Record (MAR) and observed the following medication errors: Resident A's 2:00 p.m. and 10:00 p.m. doses of Hydrocode-APAP 5-325 MG 25mg were not administered on September 1, 2021 and September 2, 2021. Resident A's 6:00 a.m. and 2:00 p.m. doses of Hydrocode-APAP 5-325 25mg were not administered on September 3, 2021.

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43. On September 15, 2021, Ms. Lewis interviewed home manager Katelyn O'Hara due to complaint allegations that on September 13, 2021 there was only one direct care worker (DCW) onsite between the hours of 3:00 p.m. and 6:00 p.m. The complaint further alleges that there are only five DCWs hired by the facility. Ms. O'Hara confirmed that these allegations are true and explained that on September 13, 2021, she received a text message from DCW Alena Dunavent at 3:30 p.m. stating that she was the only DCW present at the facility. Ms. O'Hara stated that she arrived at the facility at approximately 5:30 p.m. to assist Ms. Dunavent. Ms. O'Hara also stated that on September 11, 2021, DCW Emily Serratos was the only DCW on staff from 7:00 a.m. until 10:00 a.m.
44. During her September 15, 2021, interview Ms. Lewis asked Ms. O'Hara about allegations that Resident J missed scheduled dialysis appointments on September 9, 2021 and September 11, 2021. Ms. O'Hara confirmed that this

is true. Ms. O'Hara stated that on September 9, 2021, the driver who was to transport Resident J to the dialysis appointment arrived with an apparent injury. Resident J requested a different driver for his dialysis appointment, but alternate transportation was never provided. On September 11, 2021, the facility was responsible for transporting Resident J to his dialysis appointment, but the facility failed to provide transportation, resulting in Resident J missing another dialysis appointment.

45. On September 21, 2021, Ms. Lewis conducted an unannounced on-site investigation of the facility and reviewed the resident registrar and confirmed that the admission dates for Resident E and Resident M were not recorded. Ms. Lewis reviewed Resident O's MAR and confirmed that Resident O is required to have her blood pressure recorded daily but it was not recorded on September 10, 2021. Resident T's physician orders were reviewed, and Ms. Lewis confirmed that Resident T's weight is to be recorded weekly, but it was not recorded on June 25, 2021, July 16, 2021, August 20, 2021, August 27, 2021 and September 3, 2021.

46. During her September 21, 2021, on-site investigation Ms. Lewis reviewed weight records for all 12 of the facility residents and identified the following licensing rule violations:

    a. Resident A's weight records were not recorded in September 2020, or June 2021 through August 2021.
    b. Resident B's weight records were not recorded in January 2020 through July 2020, September 2020, February 2021 and July 2021.

c. Resident C's weight records were not recorded February 2021, May 2021 and June 2021.

d. Resident E's weight records were not recorded February 2021 and April 2021 through August 2021.

e. Resident G's weight records were not recorded January 2020, March 2020 through May 2020, February 2021 and May 2021 through July 2021.

f. Resident J's weight records were not recorded April 2021 through September 2021.

g. Resident L's weight records were not recorded September 2020, February 2021, or June 2021 through September 2021.

h. Resident M's weight records were not recorded on September 7, 2021. Additionally, Resident M is not listed on the facility's resident register and his admission date was not recorded in his resident file.

i. Resident O's weight records were not recorded May 2020, September 2020, February 2021, or April 2021 through August 2021.

j. Resident P's weight records were not recorded May 2021 or August 2021.

k. Resident U's weight records were not recorded January 2021, February 2021, or April 2021 through August 2021.

47. During her September 21, 2021, interview Ms. Lewis asked Ms. O'Hara about Resident O's medications and Ms. O'Hara stated that Resident O has not had any of her prescribed medications administered for approximately four

months. Ms. O'Hara stated that she conducted an audit of the facility residents' medications and concluded that Resident O's medications were not administered by the facility from September 1, 2021, until September 21, 2021.

48. Ms. Lewis reviewed Resident O's MAR and identified the following medications prescribed to Resident O:
    a. Amlodipine 5mg to be administered once daily.
    b. Donepezil HCL 10mg to be administered once daily on Wednesday and Friday.
    c. Fluoxetine 10mg to be administered once daily.
    d. Melatonin 3mg to be administered once daily.
    e. Memantine HCL 10mg to be administered twice daily.
    f. Mirtazapine 15mg to be administered at bedtime.
    g. Acetaminophen 325mg to be administered as needed.
    h. Alprazolam 0.25mg to be administered as needed.
    i. Promethazine HCL 25mg to be administered as needed.
49. Ms. Lewis continued to review Resident O's MAR and confirmed that Resident O's prescribed medications were not administered from September 1, 2021, through September 20, 2021. Ms. Lewis also observed notes entered by staff members to explain why Resident O's medications were not administered. The explanations included "Resident refused, med not available, waiting med arrival from pharmacy, waiting on family to bring from outside pharmacy."

50. On September 22, 2021, Ms. Lewis interviewed Joy McLeese, nurse practitioner. Ms. McLeese stated that she began working with Resident O on August 17, 2021, and confirmed that she wrote prescription refills on August 30, 2021, based on the medications identified in Resident O's MAR, which were not filled until September 20, 2021.
51. On September 23, 2021, Ms. Lewis interviewed Ms. Simpson who confirmed that on September 11, 2021, she overslept and did not arrive at the facility at the beginning of her shift at 7:00 a.m. Ms. Simpson stated that she quit working at the facility approximately two weeks ago due to feeling that the residents were not safe. Ms. Simpson stated that there are staffing issues and that Mr. Bhattad and Ms. Kumar do not seem to care about addressing issues regarding the care of the residents.
52. This AMENDED ORDER OF SUMMARY SUSPENSION AND NOTICE OF INTENT TO REVOKE replaces the ORDER OF SUMMARY SUSPENSION AND NOTICE OF INTENT TO REVOKE issued on October 6, 2021. The amendment is to correct the license number of the adult foster care large group home and to identify the facility type as a large group home.

COUNT I

The conduct of Licensee, as set forth in paragraphs 5 through 51 above,

evidences a willful and substantial violation of:

R 400.15305 Resident protection.

(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

[**Note**: By this reference paragraph 4 is incorporated into this count for the purpose of demonstrating a willful and substantial violation of the above cited licensing rule.]

COUNT II

The conduct of Licensee, as set forth in paragraphs 21, 42, 44, 45 and 47

through 50 above, evidences a willful and substantial violation of:

R 400.15312 Resident medications.

(2) Medication shall be given, taken, or applied pursuant to label instructions.

[**Note**: By this reference paragraph 4 is incorporated into this count for the purpose of demonstrating a willful and substantial violation of the above cited licensing rule.]

COUNT III

The conduct of Licensee, as set forth in paragraphs 28, 33, 36 and 40 above,

evidences a willful and substantial violation of:

R 400.15314 Resident hygiene.

(1) A licensee shall afford a resident the opportunity, and instructions when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.

[**Note**: By this reference paragraph 3 is incorporated into this count for the purpose of demonstrating a willful and substantial violation of the above cited licensing rule.]

COUNT IV

The conduct of Licensee, as set forth in paragraphs 5, 6, 7, 9, 11, 15, 16, 17, 21, 24, 27, 42, 44, 45 and 47 through 50 above, evidences a willful and substantial violation of:

R 400.15310 Resident health care.

(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following:

(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.

COUNT V

The conduct of Licensee, as set forth in paragraphs 10, 18 through 21, 25, 29, 31, 32, 34, 41, 43 & 51 above, evidences a willful and substantial violation of:

R 400.15206 Staffing requirements.

(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.

COUNT VI

The conduct of Licensee, as set forth in paragraph 37 above, evidences a willful and substantial violation of:

R 400.15311 Investigation and reporting of incidents, accidents, illnesses, absences, and death.

(6) An accident record or incident report shall be prepared for each accident or incident that involves a resident, staff member, or visitor. "Incident" means a seizure or a highly unusual behavior episode, including a period of absence without prior notice. An accident record or incident report shall include all of the following information:

(a) The name of the person who was involved in the accident or incident.

(b) The date, hour, place, and cause of the accident or incident.

(c) The effect of the accident or incident on the person who was involved and the care given.

(d) The name of the individuals who were notified and the time of notification.

(e) A statement regarding the extent of the injuries, the treatment ordered, and the disposition of the person who was involved.

(f) The corrective measures that were taken to prevent the accident or incident from happening again.

COUNT VII

The conduct of Licensee, as set forth in paragraphs 45 & 46 above, evidences a willful and substantial violation of:

R 400.15310 Resident health care.

(3) A licensee shall record the weight of a resident upon admission and monthly thereafter. Weight records shall be kept on file for 2 years.

COUNT VIII

The conduct of Licensee, as set forth in paragraph 45 & 46(h) above, evidences a willful and substantial violation of:

R 400.15210 Resident register.

A licensee shall maintain a chronological register of residents who are admitted to the home. The register shall include all of the following information for each resident:

(a) Date of admission.

DUE TO THE serious nature of the above violations and the potential risk they represents to vulnerable adults in Licensee's care, emergency action is required. Therefore the provision of MCL 24.292 of the Administrative Procedures Act of 1969, as amended, is invoked. Licensee is hereby notified that the license to operate an adult foster care large group home is summarily suspended.

EFFECTIVE 6:00 PM, on October 6, 2021, Licensee is ordered not to operate an adult foster care large group home at 8541 Eston Road, Clarkston, MI 48348 or at any other location or address. Licensee is not to receive adults for care after that time or date. Licensee is responsible for informing case managers or guardians of adults in care that the license has been suspended and that Licensee can no longer provide care.

HOWEVER, BECAUSE THE Department has summarily suspended the license, an administrative hearing will be promptly scheduled before an administrative law judge. Licensee MUST NOTIFY the Department and the Michigan Office of Administrative Hearings and Rules in writing within seven calendar days after receipt of this Notice if Licensee wishes to appeal the summary suspension and attend the administrative hearing. The written request must be submitted via MAIL or FAX to:

Michigan Office of Administrative Hearings and Rules
611 West Ottawa Street, 2nd Floor
P.O. Box 30695
Lansing, Michigan 48909
Phone: 517-335-7519
FAX: 517-763-0155

MCL 24.272 of the Administrative Procedures Act of 1969 permits the Department to proceed with the hearing even if Licensee does not appear. Licensee may be represented by an attorney at the hearing at his or her own expense.

DATED: 10-7-2021

Jay Calewarts

Jay Calewarts, Division Director
Adult Foster Care and Camps Licensing Division
Bureau of Community and Health Systems

This is the last and final page of the AMENDED ORDER OF SUMMARY SUSPENSION AND NOTICE OF INTENT in the matter of Adultcare of Independence Twp Inc, AL630007355, consisting of 25 pages, this page included.

JNH